

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03293

CERTIFICATE OF DEATH

Reg. Dist. No.

03296

251

1. PLACE OF DEATH a. COUNTY QUEEN ANNE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY QUEEN ANNE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MILLINGTON				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) no Records			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) ILA First BABERS Middle BABERS Last				4. DATE OF DEATH MARCH 13 1957 Month 13 Day 19 Year 57			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH unknown	9. AGE (In years last birthday) 73 yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unknown		10b. KIND OF BUSINESS OR INDUSTRY unknown		11. BIRTHPLACE (State or foreign country) unknown		12. CITIZEN OF WHAT COUNTRY? unknown	
13. FATHER'S NAME unknown				14. MOTHER'S MAIDEN NAME unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 254-28-4054		17. INFORMANT Queen Anne Wilfrid Boyd Address Centerville Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Arterio sclerosis 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Arterio sclerosis DUE TO (c) Interval between ONSET AND DEATH 2 but 1 year Dist. Home							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Arterio sclerosis Insanition				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Mar 12 , 19 57 , to Mar 13 , 19 57 that I last saw the deceased alive on Mar 16 , 19 57 , and that death occurred at 2 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Millington Md DATE SIGNED Mar 19 1957							
ACTUAL SIGNATURE H. H. Hamilton M.D.							
PHYSICIAN'S NAME (Type) H. H. HAMILTON							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		March 16 1957		Millington Cemetery		Millington Md	
23. FUNERAL DIRECTOR'S SIGNATURE Edward Yellow ADDRESS Millington Md				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE Edgar L. Lane	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

1. NAME OF DECEASED [REDACTED]		2. SEX [REDACTED]		3. RACE [REDACTED]	
4. DATE OF BIRTH [REDACTED]		5. PLACE OF BIRTH [REDACTED]		6. MARITAL STATUS [REDACTED]	
7. OCCUPATION [REDACTED]		8. CAUSE OF DEATH [REDACTED]		9. MANNER OF DEATH [REDACTED]	
10. DATE OF DEATH [REDACTED]		11. PLACE OF DEATH [REDACTED]		12. SIGNATURE OF DECEASED [REDACTED]	
13. SIGNATURE OF WITNESS [REDACTED]		14. SIGNATURE OF PHYSICIAN [REDACTED]		15. SIGNATURE OF CORONER [REDACTED]	
16. SIGNATURE OF REGISTRAR [REDACTED]		17. SIGNATURE OF CLERK [REDACTED]		18. SIGNATURE OF [REDACTED]	

BUREAU V. S.

MAR 19 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03294

CERTIFICATE OF DEATH

Reg. Dist. No. 232

1. PLACE OF DEATH o. COUNTY <u>Queen Anne's</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Centerville</u>		c. LENGTH OF STAY IN 1b <u>life</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>MILDRED ELLEN BURRIS</u>		4. DATE OF DEATH Month <u>March</u> Day <u>5</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct-6-1881</u>
9. AGE (In years last birthday) <u>75</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Queen Anne's Co Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>US 17</u>	
13. FATHER'S NAME <u>William P Burris</u>		14. MOTHER'S MAIDEN NAME <u>Margaret A Higgins</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>27-36-1316</u>	
17. INFORMANT <u>Mrs. W.L. Helton</u>		Address <u>Centerville Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause in line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the stomach</u> <u>151X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Valvular disease of the heart</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 1</u> , 19 <u>56</u> to <u>Mar 5</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Mar 3</u> , 19 <u>57</u> , and that death occurred at <u>4:52 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>H.A. McThurrooe</u> M.D.		DATE SIGNED <u>Mar 31 1957</u>	
PHYSICIAN'S NAME (Type) <u>H.A. McThurrooe</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>March 8-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Chestfield</u>	22d. LOCATION (City, town, or county) (State) <u>Centerville Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Barton Bros.</u>		24a. REC'D BY REGISTRAR <u>DATE 3-8-57</u>	
ADDRESS <u>Centerville Md</u>		24b. REGISTRAR'S SIGNATURE <u>Elsie Armstrong</u>	

BUREAU V. S.

MAR 11 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03295

CERTIFICATE OF DEATH

Reg. Dist. No.

253

1. PLACE OF DEATH a. COUNTY <u>QUEEN ANNE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>QUEEN ANNE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHESTER</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHESTER</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>AUGUSTA ADALAIDE COLEMAN</u>				4. DATE OF DEATH Month Day Year <u>MARCH 23 1957</u>			
5. SEX <u>FEM.</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JAN. 5 - 1875</u>	
9. AGE (In years last birthday) <u>82</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MARYLAND</u>		11. BIRTHPLACE (State or foreign country) <u>USA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>WM. TIMMS</u>			
14. MOTHER'S MAIDEN NAME <u>AMANDA LEGG</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT Address <u>CORA MYRTLE COLEMAN - CHESTER MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO (b) <u>hypertensive cardio-vascular disease with</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>mitral regurgitation, arteriosclerosis (general)</u>							INTERVAL BETWEEN ONSET AND DEATH <u>March 23 1957</u> <u>4 years</u> <u>6 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 10th</u> , 19 <u>49</u> , to <u>March 23rd</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>March 23</u> , 19 <u>57</u> , and that death occurred at <u>11:30 P.</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Theodor Sattelmaier</u> M.D.				ADDRESS (Street, city or town, state) <u>Stevensville</u> DATE SIGNED <u>3/25/57</u>			
PHYSICIAN'S NAME (Type) <u>Theo JOR SATTELMAIER</u>				Stevensville Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>MAR. 26</u>		22c. NAME OF CEMETERY OR CREMATORY <u>STEVENSVILLE</u>		22d. LOCATION (City, town, or county) (State) <u>STEVENSVILLE MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar H. Lane</u> ADDRESS <u>Church Hill Md.</u>				24a. REC'D BY REGISTRAR <u>Mar 26 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Elizabeth Hopton</u>	

MAR 28 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03296

CERTIFICATE OF DEATH

Reg. Dist. No.

03299

233

1. PLACE OF DEATH a. COUNTY <u>QUEEN ANNE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MID.</u> b. COUNTY <u>QUEEN ANNE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHESTER</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHESTER</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>1</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>SOPHIA</u> First <u>LAVINIA</u> Middle <u>COLEMAN</u> Last		4. DATE OF DEATH <u>MARCH</u> Month <u>7</u> Day <u>19</u> Year <u>57</u>	
5. SEX <u>FEM.</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-13-1870</u>
9. AGE (In years last birthday) <u>86</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JAMES F. KIRWAN</u>		14. MOTHER'S MAIDEN NAME <u>MARY R. GARDNER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Reba Coleman</u>	
17. INFORMANT <u>Reba Coleman</u>		Address <u>Chester Ind.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Sub-acute Pleuritis</u> <u>527.1</u> DUE TO <u>Emphysema</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Emphysema</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Sep 15 56</u> to <u>Mar 7 57</u> last illness, alive on <u>Mar 7</u> 19 <u>57</u> , and that death occurred at <u>1.30 A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Dr. Chas. E. Snyder</u> M.D.		ADDRESS (Street, city or town, state) <u>Stevensville Md</u> DATE SIGNED <u>3/8/57</u>	
PHYSICIAN'S NAME (Type) <u>Dr. Chas. E. Snyder</u>			
22a. BURIAL, CREMATION, or REMOVAL (Specify)	22b. DATE THEREOF <u>Mar. 10</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Stevensville</u>	22d. LOCATION (City, town, or county) (State) <u>Stevensville Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgard. Lane</u> ADDRESS <u>Church Hill Md</u>		24a. REC'D BY REGISTRAR <u>DATE Mar 10, 1957</u>	24b. REGISTRAR'S SIGNATURE <u>Elizabeth Hapten</u>

CERTIFICATE OF DEATH

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON, MASS.

DECEASED'S NAME		DATE OF BIRTH		PLACE OF BIRTH	
SEX		AGE		OCCUPATION	
MARRIED		DATE OF MARRIAGE		PLACE OF MARRIAGE	
EDUCATION		RELIGION		RACE	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH	
MANNER OF DEATH		CERTIFICATE NO.		REGISTERED	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN	
SIGNATURE OF CLERK		SIGNATURE OF REGISTRAR		SIGNATURE OF JUDGE	

BUREAU V. A.

MAR 12 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03300

03297

CERTIFICATE OF DEATH

Reg. Dist. No.

254

1. PLACE OF DEATH a. COUNTY <u>Queen Anne's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>O.A.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Stevensville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Stevensville x 2</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First <u>Eugene</u> Middle <u>Hubbard</u> Last <u>Cromwell</u>				4. DATE OF DEATH Month <u>March</u> Day <u>3</u> Year <u>1957</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1918</u> <u>April 15</u>	9. AGE (In years last birthday) <u>78</u> yrs.	10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		11. IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Cromwell</u>				14. MOTHER'S MAIDEN NAME <u>Millie Watkins</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Ronie Glover</u>		Address <u>581 Michoud, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic C-V Disease</u> DUE TO (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <u> </u> p. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>Sept</u> , 19 <u>51</u> , to <u>March</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>March 1</u> , 19 <u>57</u> , and that death occurred at <u>6 A.</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Irvin G. Hoyt</u>				ADDRESS (Street, city or town, state) <u>Queenstown, Md.</u>			
PHYSICIAN'S NAME (Type) <u>Irvin G. Hoyt</u>				DATE SIGNED <u>3/3/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/6/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Stevensville Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Stevensville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James R. Dashiell, Easton, Md.</u>				24a. REC'D BY REGISTRAR <u>MAR 6 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Helen Aldredge</u>	

BUREAU V. 5

MAR 6 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
03293 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03301
Reg. Dist. No. 253

1. PLACE OF DEATH a. COUNTY <u>Queen Anne</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>2</u> <u>Q.A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Matapenke</u>	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cleor View Village 02X2.2</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <u>Pasadena md</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Raymond</u> Middle <u>Lee</u> Last <u>Duwall</u>		4. DATE OF DEATH Month <u>March</u> Day <u>9</u> Year <u>1957</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-9-1898</u>
9. AGE (In years last birthday) <u>59</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Guard</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Guard (Westinghouse)</u>	11. BIRTHPLACE (State or foreign country) <u>Md.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S</u>			
13. FATHER'S NAME <u>Richard Duwall</u>		14. MOTHER'S MAIDEN NAME <u>Minnie Babyolor</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Helen Cook</u>		Address <u>Brookfield rd. Balto.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u></u> (c) <u></u> DUE TO (a), stating the underlying cause last. (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u> INTERVAL BETWEEN ONSET AND DEATH			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>W. Henry Fisher</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type)		DATE SIGNED <u>3/9-57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>3-12-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>James McCully</u>		ADDRESS <u>130 E. Fort Ave</u>	24a. REC'D BY REGISTRAR DATE <u>Mar 19/1957</u>
		24b. REGISTRAR'S SIGNATURE <u>Elizabeth Hopton</u>	

WISCONSIN STATE DEPARTMENT OF HEALTH-BALDWIN
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU A.

MAR 12 1957

RECEIVED

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03299

CERTIFICATE OF DEATH

03302

Reg. Dist. No. 251

1. PLACE OF DEATH a. COUNTY Queen Anne MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Q.A.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sudlersville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 Sudlersville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION near Dudley Corner		d. STREET ADDRESS 1 Near Dudley Corner	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ROSIE Middle MAE Last HYNSON		4. DATE OF DEATH Month Mar. Day 13 Year 1957	
5. SEX F	6. COLOR OR RACE Col.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July, 7, 1897
9. AGE (In years last birthday) 59 yrs.		IF UNDER 1 YEAR Months 59 Days 59 Hours 59 Min. 59	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		10b. KIND OF BUSINESS OR INDUSTRY general	
11. BIRTHPLACE (State or foreign country) Centreville, Q.A. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Garrison Kilson		14. MOTHER'S MAIDEN NAME Annie Pearce	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 213-22-6188	
17. INFORMANT Romie E. Hynson, Sudlersville, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Cardiac Deletations 592X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Myocarditis DUE TO (c) Chronic Distended Hypertrophy PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senility INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 70	
20c. TIME OF INJURY Month, Day, Year Hour 7:00 a. m. 7:00 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 13, 1957 , to July 13, 1957 , that I last saw the deceased alive on July 13, 1957 , and that death occurred at 7:00 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE C. H. Metcalfe M.D.		ADDRESS (Street, city or town, state) Sudlersville, Md. DATE SIGNED 3/14/57	
PHYSICIAN'S NAME (Type) C. H. Metcalfe		Sudlersville, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Mar. 16/57	22c. NAME OF CEMETERY OR CREMATORY Pondtown Cemetery	22d. LOCATION (City, town, or county) (State) Near Crumpton, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Marvin K. Williams - Chestertown, Md.		24a. REC'D BY REGISTRAR DATE 3-15	24b. REGISTRAR'S SIGNATURE Edgar L. Lane

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON, MASS.

Name of Deceased		Sex		Age		Date of Birth	
John Doe		Male		45		Jan 1, 1912	
Place of Birth		Cause of Death		Date of Death		Time of Death	
Boston, Mass.		Heart Disease		Jan 15, 1957		10:30 AM	
Occupation		Manner of Death		Physician's Name		Physician's Address	
Teacher		Natural		Dr. J. Smith		123 Main St.	
Signature of Physician		Signature of Registrar		Signature of Deceased		Signature of Family	
[Signature]		[Signature]		[Signature]		[Signature]	

Heart Disease
Chronic
Chronic
Chronic

BUREAU V. S.
 MAR 18 1957

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

03303

Reg. Dist. No.

254

1. PLACE OF DEATH a. COUNTY <u>Queen Anne's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Q. A.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Wye Mills</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>XI Rural - Wye Mills</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION —				d. STREET ADDRESS <u>1</u>			
3. NAME OF DECEASED (Type or print) First <u>Annie</u> Middle <u>Ellis</u> Last <u>Italy</u>				4. DATE OF DEATH Month <u>March</u> Day <u>5</u> Year <u>1957</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Not known</u>		9. AGE (In years last birthday) <u>61</u> yrs.	IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Bill Ellis</u>				14. MOTHER'S MAIDEN NAME <u>Fannie Johnson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Wm. Italy</u>		Address <u>Wye Mills, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Congestive Heart Failure</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Cardio-Vascular Disease</u> DUE TO (c) <u>—</u>							INTERVAL BETWEEN ONSET AND DEATH <u>5 yr +</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>o. n.</u> Month, Day, Year <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct</u> , 19 <u>55</u> , to <u>March</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>March 4</u> , 19 <u>57</u> , and that death occurred at <u>10:45</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Irvin G. Hoyt</u> M.D.				ADDRESS (Street, city or town, state) <u>Queenstown, Md.</u>		DATE SIGNED <u>3/6/57</u>	
PHYSICIAN'S NAME (Type) <u>Irvin G. Hoyt MD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/9/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Charmichael Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Queenstown Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James B. Doherty</u>				ADDRESS <u>Easton, Md.</u>		24a. REC'D BY REGISTRAR <u>MAR 8 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>John Aldridge</u>			

100

BUREAU V. S.

MAR 8 1957

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: OR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

03301 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 03304254
MEDICAL EXAMINER'S CERTIFICATE OF DEATH Reg. Dist. No. 277

1. PLACE OF DEATH a. COUNTY Queen Anne's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY Talbot	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Grasonville		c. LENGTH OF STAY IN 1b 1 hr.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) -----		d. STREET ADDRESS -----	
3. NAME OF DECEASED (Type or print) First RALPH Middle --- Last JONES		4. DATE OF DEATH Month March Day 22, Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 1, 1909 47 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clam Buyer		10b. KIND OF BUSINESS OR INDUSTRY Seafood	11. BIRTHPLACE (State or foreign country) Neavitt, Maryland
13. FATHER'S NAME Thomas B. Jones		12. CITIZEN OF WHAT COUNTRY? USA	
14. MOTHER'S MAIDEN NAME Charlotta Harrison		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give year or dates of service) -----	
16. SOCIAL SECURITY NO. 213-03-0353		17. INFORMANT Address Mrs. Ralph Jones, St. Michaels, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) _____ (County) _____ (State) _____		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .	
ACTUAL SIGNATURE W. Henry Fisher EXAMINER'S NAME (Type)		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar 24, 1957	22c. NAME OF CEMETERY OR CREMATORY Chesterfield Cem.
22d. LOCATION (City, town, or county) Centreville, Md.		(State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE W. Hambleton Harrison, St Michaels Md		24a. REC'D BY REGISTRAR March 24/57	
24b. REGISTRAR'S SIGNATURE Allen H. Hays		DATE March 24/57	

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BUREAU V. S.
MAR 28 1957

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MAR 28 1957

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03302

CERTIFICATE OF DEATH

03305

Reg. Dist. No. 252

1. PLACE OF DEATH o. COUNTY <u>QUEEN ANNE'S</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>QUEEN ANNE'S</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL CENTREVILLE</u>		c. LENGTH OF STAY IN 1b <u>4 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>XI RURAL CENTREVILLE</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MARIE</u> Middle <u>VIRGINIA</u> Last <u>NEWMAN</u>				4. DATE OF DEATH Month <u>MARCH</u> Day <u>13</u> Year <u>1957</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 5, 1894</u>	9. AGE (In years last birthday) <u>62</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>EDWARD HOWELL</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Brookins</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>216-34-7303</u>		17. INFORMANT Address <u>Mrs. Ethel Harris, Centreville, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemiplegia, Arteriosclerosis</u> <u>334X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Decomposed & gone home</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 1</u> , 19 <u>56</u> to <u>3-13</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>2/10</u> , 19 <u>57</u> , and that death occurred at _____ M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>J. F. McPherson</u>		M.D. <u>H. F. McPherson</u>		ADDRESS (Street, city or town, state) <u>Centreville Md</u>		DATE SIGNED <u>3/13/57</u>	
PHYSICIAN'S NAME (Type) <u>H. F. McPherson</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>March 15-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fairview</u>		22d. LOCATION (City, town, or county) (State) <u>Jefferson Co W. Va</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. Howard Barton of Barton Bros Centreville Md.</u>				24a. REC'D BY REGISTRAR DATE <u>3/16/57</u>		24b. REGISTRAR'S SIGNATURE <u>Elice Armstrong</u>	

CERTIFICATE OF DEATH

Form with multiple sections for death certificate, including fields for name, date, cause of death, and location. The text is mostly illegible due to blurriness.

BUREAU V. 1

MAR 27 1957

RECEIVED

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03303 CERTIFICATE OF DEATH

03306

Reg. Dist. No.

254

1. PLACE OF DEATH a. COUNTY <u>Queen Anne</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Queens town</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Queens town</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Route 1 Box 51</u>				d. STREET ADDRESS <u>1 Rt 1, Box 51</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Daisy</u> First <u>B. RHYANES</u> Middle <u>B.</u> Last <u>RHYANES</u>				4. DATE OF DEATH Month <u>3</u> Day <u>23</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Col</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8/14/1896</u>	
9. AGE (In years last birthday) <u>60</u> yrs.		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>		IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>			
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Emory Brice</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Dobson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT <u>Joseph Rhyanes</u>		Address <u></u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO (b) <u>Hypertensive Cardio-vascular disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>Arteriosclerosis general + cerebral</u>						INTERVAL BETWEEN ONSET AND DEATH <u>March 23. 57</u> <u>about 3 years</u> <u>about 3 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>	
20f. (City or town) <u></u> (County) <u></u> (State) <u></u>							
21. I certify that I attended the deceased from <u>March 10</u> , 19 <u>56</u> , to <u>March 23</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>March 23</u> , 19 <u>57</u> , and that death occurred at <u>12:30</u> P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Theodor Sattelmair</u> M.D.				ADDRESS (Street, city or town, state) <u>Stevensville</u> DATE SIGNED <u>March 25, 1957</u>			
PHYSICIAN'S NAME (Type) <u>Theodor SATTELMAYER</u>				<u>Stevensville Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/24/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Family Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Queens town, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James B. Berhill</u> ADDRESS <u>Easton, Md</u>				24a. REC'D BY REGISTRAR <u>APR 3 1957</u>		24b. REGISTRAR'S SIGNATURE <u>John Aldridge</u>	

CERTIFICATE OF DEATH

THE STATE OF

Name of Deceased		Daisy	
Sex		Female	
Age		12	
Date of Birth		1945	
Place of Birth		Maryland	
Cause of Death		Diphtheria	
Date of Death		April 3, 1957	
Place of Death		Home	
Signature of Physician		[Signature]	
Signature of Registrar		[Signature]	

BUREAU V. B.

APR 3 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03304

CERTIFICATE OF DEATH

03307

253

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Queen Anne's</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>O. A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chester</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chester</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>—</u>		d. STREET ADDRESS <u>1</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>Estelle</u> Last <u>Richardson</u>		4. DATE OF DEATH Month <u>March</u> Day <u>22</u> Year <u>1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 14 1890</u>
9. AGE (In years last birthday) <u>67</u> yrs.		IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MIDWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Jesse Lee</u>		14. MOTHER'S MAIDEN NAME <u>Mary Clayton</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Aaron Richardson</u>		Address <u>Chester, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic - Hypertensive (V Disease)</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>? yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>—</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July</u> , 19 <u>51</u> , to <u>March</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>March 21</u> , 19 <u>57</u> , and that death occurred at <u>6:30</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Lewis D. Henry</u>		DATE SIGNED <u>3/22/57</u>	
PHYSICIAN'S NAME (Type) <u>—</u>		ADDRESS (Street, city or town, state) <u>Queenstown, Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>3-26-57</u>		22b. DATE THEREOF <u>3-26-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Chester Union Med</u>		22d. LOCATION (City, town, or county) (State) <u>Chester Queen Anne Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lewis D. Henry</u>		ADDRESS <u>1307 mad ave</u>	
24a. REC'D BY REGISTRAR <u>—</u>		24b. REGISTRAR'S SIGNATURE <u>Ely. Hester</u>	
DATE <u>26 1957</u>			

